

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-045842

State File No.

FILED JAN 12 1959

Registrar's No. **12677**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 3/ St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 2/39 5400 Arsenal St., St. Louis 9, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) MARION b. (Middle) WALLACE c. (Last) HURD		4. DATE OF DEATH (Month) (Day) (Year) Dec. 29th, 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-16-11903
9. AGE (In years) (Last birthday) 55		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY formerly: Waiter
11. BIRTHPLACE (City and State or Foreign Country) Hillsboro, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Althea Hurd (Jackson)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Althea Hurd, Alton, Illinois.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Syphilitic heart disease with congestive failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CNS lues; general paresis DUE TO (c) 023X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 2, 1941, to Dec. 29, 1958, that I last saw the deceased alive on Dec. 29, 1958, and that death occurred at 10:30^a p.m., from the causes and on the date stated above.

23a. SIGNATURE L. J. Hoppe	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 12-29-58
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-29-58	24c. NAME OF CEMETERY OR CREMATORY Alton, Illinois.

DATE REC'D BY LOCAL REG. DEC 30 '58	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or~~ by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed... *Lawrence O. Gault*

Licensed Embalmer No. ... *497* ...

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.